

# IMMUNIZATION RECORDS FORM

**PARENT/GUARDIAN:** All immunizations are required by state regulations (105CMR 220.00) for entrance to school. Please provide this form to your student's primary care provider to complete and sign. Then return this with the Physical Examination Form to the Cathedral Health Office.

**PRIMARY CARE PROVIDER:** Please complete each immunization with month and year, sign and return to the parent or guardian.

## 1 STUDENT IMMUNIZATION DETAILS

NAME OF STUDENT

DTP/DT	1ST	2ND	3RD	4TH	5TH
TD BOOSTER (MUST BE WITHIN 5 YEARS OF LAST DPT & EVERY 5 YEARS)	1ST	2ND	3RD	4TH	5TH
OPV/IPV	1ST	2ND	3RD	4TH	
HEP B	1ST	2ND	3RD		
HIB	1ST	2ND	3RD		
MMR	1ST	2ND			
CHICKENPOX	1ST				
VARICELLA (OR TITER RESULTS W/DATE)	1ST				
TB RISK ASSESSMENT	1ST				

☐ LOW RISK ☐ HIGH RISK

**IF STUDENT IS ASSESSED BY PROVIDER AS HIGH RISK FOR TB, THE RESULTS OF A PPD WITHIN THE LAST YEAR MUST BE RECORDED BELOW:**

PPD DATE	RESULTS
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## 2 PROVIDER INFORMATION

PROVIDER NAME	PHONE
PROVIDER SIGNATURE	DATE
ADDRESS OF PRACTICE	



**CATHEDRAL**  
7-12 HIGH SCHOOL • BOSTON

**PLEASE RETURN THIS COMPLETED FORM TO:**

**MAIL:** Cathedral 7-12 High School, *Health Office*, 74 Union Park St., Boston MA 02118

**FAX:** (617) 542-1745